STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

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F0000	This visit was for the Investigation of Complaints IN00116232, IN00116313, and IN00117473. This resulted in a partially extended survey-Immediate Jeopardy. Complaint IN00116232 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00116313 - Substantiated. Residential finding related to the allegations is cited at R349. Complaint IN00117473 - Substantiated. Federal/state deficiencies related to the allegation are cited at F225 and F226. Unrelated deficiencies cited. Survey dates: October 4, 2012 Extended survey dates: October 5 & 9, 2012 Facility number: 010739 Provider number: 155764 AIM number: 200856890 Survey team: Janet Adams, RN, TC	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Janelyn Kulik, RN October 5, 2012 Census bed type: SNF: 49 SNF/NF: 5 Residential: 62 Total: 116 Census payor type: Medicare: 43 Medicaid: 5 Other: 68 Total: 116 Sample: 3 Supplemental sample: 3 Residential Sample: 8 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 10/15/12 by Suzanne Williams, RN			

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F0225 SS=K	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. A. Based on record review and	F0225	Resident #C was transferred to the	11/08/2012

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	interview, the facility failed to ensure a thorough investigation was conducted for a new onset of vaginal bleeding noted for a resident who was cognitively impaired and required extensive assistance from staff for completing activities of daily living. The facility also failed to ensure a thorough investigation was completed when an allegation was made indicating this resident had injuries that were not self inflicted, and a vaginal tear was documented in hospital records. This affected 1 of 3 residents reviewed for allegations of abuse in the sample of 3. (Resident #C) Due to the lack of thorough investigation, this deficient practice had the potential to affect the 54 residents residing on the health care units who were not protected from further potential abuse, of the 116 residents residing in facility. In addition, the facility failed to immediately report and initiate investigations in a timely manner for 2 of 2 residents in the sample of 3 who voiced mistreatment by staff and failed to suspend the employees involved in the allegations (Residents #B and #D), and failed to initiate an investigation and report a resident to resident altercation for 1 of 2 resident to resident altercations reviewed in the supplemental sample of 3.		hospital on 9/23/12 for evaluation and treatment of vaginal bleeding. We received verbal notification from the hospital that Resident #C was being admitted with postmenopausal vaginal bleeding. The ER reported dated 9/23/12 also indicated no signs of injury around the vagina. Our plan at that time was to communicate with the family to monitor this resident's condition with anticipated return to our facility. On October 5, 2012, ISDH surveyors initiated a survey at Spring Mill Health Campus to investigate. Between the dates of 9/23/12 and 10/5/12, the facility had no reason to investigate what was believed to be a medical condition and diagnosis. As soon as we were notified of suspicion that the injuries could have been self inflicted or otherwise inflicted, we immediately initiated a full investigation. This resident had already been transferred out of the facility when we learned of the allegation and/or need for investigation. There was no additional need for corrective action(s) for this resident. Facility did a house wide audit of all incident and accidents to validate a through investigation was completed and report to Indiana State Department of Health. No other findings were noted. Audit was completed on 10/5/2012. All Department Heads were in serviced on 10/5/2012 by the ED,	

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	(Residents #E and #J) The Immediate Jeopardy began on 9/23/12 when Resident #C was observed with a new onset of vaginal bleeding and an investigation into the bleeding was not initiated. The facility Executive Director, Interim Director of Health Services, and Clinical Support Nurse were notified of the Immediate Jeopardy on 10/4/12 at 4:50 p.m. The Immediate Jeopardy was removed on 10/5/12 at 6:00 p.m., but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. B. Based on record review and interview, the facility also failed to ensure reference checks were completed during the hiring process for 1 of 5 employee files reviewed (RN #1). Findings include: A.1. The closed record for Resident #C was reviewed on 10/4/12 at 1:30 p.m. The resident's diagnoses included, but were not limited to, dementia, Alzheimer's disease, major depressive disorder, high blood pressure, and coronary artery		DHS and/or SS concerning the Abuse & Neglect and Accident and Incident reporting guidelines. This inservice included the expectation that all reports of alleged abuse must be immediately reported to the Executive Director or designee in his/her absence. An investigation should begin immediately with to include reporting of required state agencies per our Abuse Policy and the Elder Justice Act. Staff accused of abuse will be suspended pending investigation. In addition to department heads being trained, all staff have been inserviced on this policy 10/30/12. Resident identifiers were not provided to the facility. Facility staff conducted a survey on 10/5/2012 of interviewable residents ensure they feel safe, their needs are being met and privacy and dignity maintained. All concerns identified during this survey have been reported to facility staff and addressed as indicated. Any issues pertaining to known, suspected or alleged/abuse have been reported to the Indiana State Department of Health with investigations in process as applicable. Resident interviews will be conducted with five (5) residents weekly will be conducted by Social Services or designee to ensure residents feel safe, needs are met and privacy/dignity is maintained. Resident to resident altercations was	

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	disease. The resident was sent to the hospital on 9/23/12. Review of the 8/16/12 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 2. This indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required extensive assistance from staff for personal hygiene, eating, dressing, and toilet use. The assessment also indicated the resident required extensive assistance of two or more persons for bed mobility and transfers. A care plan, initiated on 8/13/12, indicated the resident had impaired cognitive skills as evidenced by decision making problems and memory problems. Another care plan, initiated on 8/13/12, indicated the resident had impaired communication, or the potential for, as her primary language was not English. Care plan interventions included for a communication board to be utilized as an alternate form of communicating. The 9/2012 Nurses' Notes were reviewed. The first entry made on		also reviewed with staff to make sure everyone had a clear understand that these should also be considered as an allegation of abuse in some instances. Audits to continue 5 residents weekly for 90 days; then 3 residents weekly for 60 days; then 2 residents weekly for 30 days. We will review in QA monthly until substantial compliance is achieved. Resident concerns will be reviewed by the Executive Director or designee five (5) times per week with timely reporting of known, suspected or alleged abuse and immediate initiation of the investigative process. This will be an ongoing process. We reviewed all personnel files to ensure we were in compliance with all aspects of our Abuse and Neglect Procedural Guidelines. Part of our guidelines include obtaining reference checks for all employees. Any personnel files identified that were missing reference checks have been corrected. Department Heads have been re-trained on the importance of obtaining these reference checks. Our HR Manager will oversee compliance with this expectation. All new employees hired will have reference checks completed before they complete orientation. This will be reported to QA Committee monthly x 4 months then randomly thereafter until concern is determined resolved by	

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	9/23/12 was completed at 10:00 a.m. This entry indicated the resident presented with vaginal bleeding. The Physician and family were notified and orders were obtained to send the resident to the hospital for an evaluation and treatment. There was no assessment of the resident's vaginal area in this entry. There was only one entry made on 9/22/12. This entry was made at 11:00 a.m. There was no documentation of the resident having any vaginal bleeding in this entry. There was only one entry made on 9/21/12. This entry was made at 5:00 p.m. There was no documentation of the resident having any vaginal bleeding in this entry. Hospital documents from the Emergency Room, which were in the resident's clinical record, were reviewed. There was a faxed date of 9/28/12 typed on the top right hand corner, indicating they were faxed to the facility on 9/28/12. Emergency Room records dated 9/23/12 indicated the resident was sent to the Emergency Room for an evaluation of vaginal bleeding, and the resident had a history of having a hysterectomy and cardiac surgery. The records indicated there was bleeding around the vagina, no signs of injury around the vagina, and blood		QA committee. QA will monitor for any trends and make recommendation to plan of correction as needed. QA will monitor for six (6) months or until compliance is achieved. Correction of citation is 11/8/12	

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	clots and discharge from the vagina. The records also indicated the Physician was unable to evaluate the cervix due to the resident being uncooperative, as the resident did not follow commands and was not orientated. Additional hospital records were obtained on 10/4/12 at 3:00 p.m. A 9/23/12 Internal Medicine note, completed by the Physician who was the resident's attending Physician at the facility she was admitted from, indicated the resident was not able to communicate anything, had severe Alzheimer's disease, and the resident was seen in the Emergency Room. The note confirmed the resident was having bleeding from the vagina and not the rectum. A pelvic examination indicated the resident was actively bleeding from the vagina and no bleeding was noted upon a rectal exam. The note also indicated the resident was status post hysterectomy and the cause of the bleeding was not very clear and a Gynecology consultation was to be obtained for further evaluation. The note also indicated the resident "might have a vaginal wall cancer of some ulcer, possibility of maceration with a hard object should also be considered in demented patient which			

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	may have caused laceration and bleeding." A Gynecology Consult Note dated 9/23/12 indicated the resident was admitted for vaginal bleeding and an examination under anesthesia was required. A 9/25/12 Physician Progress Note, completed by the resident's attending Physician, indicated the Gynecologist "observed that there was a tear and other than blood there was a yellow fluid came out [sic] he is concerned that she may have injured her vagina wall with a hard object and may have even rupture [sic] urinary bladder wall." An Operative Record dated 9/26/12 indicated an examination was performed under anesthesia and a speculum examination was done. Small abrasions were noted at the vaginal vault and some bleeding was noted. The abrasions were cauterized. A 9/26/12 Physician Progress Note, completed by the resident's attending Physician, indicated the resident had a pelvic examination under general anesthesia and was found to have a tear in the vagina. The Assessment section of the note indicated "vaginal bleeding....did she masturbate with a			

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	hard object or was it a sexual abuse in the nursing home cannot be determined as patient is demented and cannot give a history..." When interviewed on 10/4/12 at 2:10 p.m. Social Worker #1 indicated the resident's son came into the facility to pick up the resident's dentures and eye glasses on 9/24/12. The Social Worker indicated she gave them to the resident's son at that time. The Social Worker indicated the resident's son did not say anything about the resident's condition at this time. The Social worker indicated the resident's son came back to the facility another time after the above date. The Social Worker indicated he came back to the facility with another person. The Social Worker indicated she could not remember the exact date of this visit. The Social Worker indicated she asked the son how he was doing and the other visitor told the son "don't say anything." The Social Worker indicated she then asked the son and the other visitor if there was something wrong and requested they come into her office to talk. The Social Worker indicated the other visitor indicated "she has injuries and they are not self inflicted, and we may have a case." The Social Worker indicated to both of them she was			

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	going to call the Executive Director to come and talk with them. The Social Worker indicated she tried calling and paging the Executive Director while they were both still in her office but did not get an answer, and the resident's son and the other visitor gave her a business card and left the facility. The Social Worker indicated she then went to the Executive Director's office and informed her what had happened in her office, and that the visitor indicated the resident had injuries that were not self inflicted and gave the card to the Executive Director. When interviewed on 10/4/12 at 2:35 p.m., the Executive Director indicated the Social Worker informed her of the resident's son and the visitor being in the facility and indicating the resident had some vaginal bleeding and it was "not self inflicted." She indicated this was either last Thursday or Friday. The Executive Director indicated at that time she reviewed the resident's clinical record and called the hospital for the Emergency Room records. The Executive Director reviewed the Emergency Records that were in the resident's record and indicated the date of the fax written on the records was the date the visitors were in and this date was 9/28/12. The Executive			

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	Director indicated she also then spoke with the Nurse who was caring for the resident at the time she was sent to the hospital on 9/23/12, the CNA who was working that shift, and the Nurse who worked the shift before. The Nurse who sent the Resident #C to the hospital for the vaginal bleeding indicated this was the first time the resident had any vaginal bleeding. The Nurse on the night shift indicated there were no problems with the resident in the night shift. When interviewed on 10/4/12 at 3:20 p.m., the Executive Director indicated she spoke to the male CNA caring for the resident on the day she was sent out to the Emergency Room and asked him if he had noticed any bleeding in the resident's brief or if there had been any problems with the resident, and none were voiced. The Executive Director indicated the three staff members were interviewed, but no written statements were available. The facility policy, titled "Abuse and Neglect Procedural Guidelines," was reviewed on 10/4/12 at 12:45 p.m. The policy had a revised date of 9/16/2011. The policy indicated the Executive Director was accountable for investigating and reporting			

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	allegations. The policy also indicated the Incident and Accident Program was to be referred to for investigation procedures. The facility policy, titled "Accident and Incident Reporting Guidelines," was reviewed on 10/4/12 at 2:00 p.m. The policy was dated 11/2010. The policy indicated all accidents, incidents, and allegations of abuse, including injuries of unknown source, were to be reported to the department supervisor as soon as discovered or when information of occurrence is learned. The policy also indicated reporting of incidents, accidents, and abuse to state and federal agencies shall be in accordance with agency guidelines. The Immediate Jeopardy that began on 9/23/12 was removed on 10/5/12 when the facility inserviced staff on the Abuse Policy and procedures and reporting any unusual occurrence to their supervisor at the time of the occurrence. All staff working on 10/5/12 had been inserviced. The facility interim Director of Nursing provided a listing of all facility employees with a monitoring system to ensure each employee was inserviced prior to the start of their next scheduled shift. Department Heads were inserviced on the facility			

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	Accident and Incident Reporting guidelines to include immediate reporting to the Executive Director/DHS (Director of Health Services) and initiation of investigations. Random verbal audits of several residents were initiated to ensure residents felt safe and their needs were addressed. The audits were to continue. An investigation of Nursing Staff assigned as working the unit for 24 hours prior to the incident was initiated. Incident logs from 7/2012 to current were reviewed for any other potential occurrences. The Immediate Jeopardy was removed on 10/5/12 at 6:00 p.m., but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because inservicing needed to be provided to all staff prior to returning to work and the facility needed to ensure ongoing monitoring was in place to ensure all allegations of abuse or mistreatment were evaluated thoroughly. A.2. The record for Resident #B was reviewed on 10/4/12 at 10:00 a.m. The resident's diagnoses included, but were not limited to, spinal stenosis, breast cancer, and coronary			

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	artery disease. The 7/5/2012 Minimum Data Set (MDS) admission assessment indicated the BIMS (Brief Interview for Mental Status) score was 15. This score indicated the resident's cognitive patterns were intact. An Indiana State Department of Health Incident Report Form was reviewed on 10/4/12 at 10:30 a.m. This incident report form indicated an incident occurred on 8/12/12 at 3:45 p.m. The form indicated the resident reported she did not want the CNA from the midnight shift taking care of her as the CNA was mean and nasty. The report indicated the Immediate Action taken included suspension of CNA #1 and initiating an investigation. The form also indicated the Executive Director was notified. An Accident/Incident Report was initiated on 8/12/12. The report indicated the resident complained that a CNA was mean and nasty to her and would not help her move her leg. The incident occurred on 8/12/12 at 3:45 p.m. The report also indicated this was reported to the Unit Manager and the resident had no injury. The report was signed as completed by the RN Unit Manager.			

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	The facility's investigation was reviewed. The investigation indicated CNA #1 was identified as the CNA working on the night shift 8/11/12 through 8/12/12. The employee time card record for CNA #1 indicated the employee did work the night shift starting on 8/12/12 at 9:57 p.m. and ending on 8/13/12 at 6:13 a.m. When interviewed on 10/4/12 at 11:50 a.m., LPN #6 indicated she was in the resident's room with a CNA on 8/12/12 and the resident voiced the concern that a CNA on the night shift had been mean to her. The LPN indicated she filled out a concern form at the time and reported the concern to the Unit Manager, who was in the facility at the time the above concern was reported to her. When interviewed on 10/4/12 at 12:25 p.m., the Unit Manager indicated on 8/12/12 at around 3:00 p.m. the Nurse reported to her that Resident #B had indicated a staff member was mean to her. The Unit Manager indicated she was in the facility at the time the Nurse reported this to her. The Unit Manager indicated she did not report this to anyone until the next day when she informed the DON. The Unit Manager indicated the DON then			

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	instructed her to interview Resident #B. When interviewed on 10/4/12 at 12:05 p.m., the Executive Director indicated CNA #1 was not suspended at the time the allegation was reported to the Unit Manager as per the facility policy. The Executive Director indicated the CNA time card indicated the CNA worked the night shift on 8/12/12 after the incident was reported on 8/12/12 at 3:45 p.m. The facility policy, titled "Abuse and Neglect Procedural Guidelines," was reviewed on 10/4/12 at 12:45 p.m. The policy had a revised date of 9/16/2011. The policy indicated the Executive Director was accountable for investigating and reporting allegations. The policy also indicated the Incident and Accident Program was to be referred to for investigation procedures. The policy also indicated upon identification of suspected abuse and neglect protection for the safety of the resident is to be provided and may included 1:1 monitoring, moving of the resident, and suspending employees pending the outcome of the investigation. A.3. The record for Resident #D was reviewed on 10/4/12 at 11:30 a.m.			

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	The resident's diagnoses included, but were not limited to, coronary artery disease, atrial fibrillation (an irregular heart beat) and congestive heart failure. The 9/21/12 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 15. This indicated the resident's cognitive patterns were intact. A Resident Concern form was initiated by Social Service #2 on 9/22/12 at 3:35 p.m. The form indicated the resident informed the above staff member he would like to speak to the Unit Manager or DHS (Director of Health Services) regarding a CNA on the midnight shift had refused to help him reposition in bed and told him he do can it himself. An Indiana State Department of Health Incident Report Form was reviewed on 10/4/12 at 10:30 a.m. The report form indicated an incident occurred on 9/22/12 at 3:45 p.m. The incident description indicated the resident verbalized to Social Service #2 that a CNA on the midnight shift refused to help him reposition in bed. The report indicted the Immediate Action taken included suspension of			

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	the CNA and initiating an investigation. Review of the facility's investigation indicated the DON interviewed Resident #D and CNA #6 on 9/25/12. Review of CNA #6's time card records indicated the CNA worked the night shift on 9/23/12. The CNA started work at 9:57 p.m. on 9/23/12 and punched out on 9/24/12 at 6:03 a.m. When interviewed on 10/4/12 at 1:10 p.m., the Clinical Support Nurse indicated the Social Service staff did not inform management of the concern until the staff morning meeting on 9/24/12, and the Social Service staff indicated they then informed her the resident's concern was an allegation of abuse and needed to be investigated and an investigation was started. When interviewed on 10/4/12 at 1;15 p.m., the Executive Director indicated she was first aware of the resident's concern at the 9/24/12 morning staff meeting and instructed the DON to initiate an investigation. The Executive Director indicated the CNA was not suspended at the time of the allegation. The Executive Director indicated the CNA did not work after 9/24/12 when the allegation was first			

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	brought up by Social Service at the 9/24/12 morning staff meeting. The facility policy, titled "Abuse and Neglect Procedural Guidelines," was reviewed on 10/4/12 at 12:45 p.m. The policy had a revised date of 9/16/2011. The policy indicated the Executive Director was accountable for investigating and reporting allegations. The policy also indicated the Incident and Accident Program was to be referred to for investigation procedures. The policy also indicated upon identification of suspected abuse and neglect protection for the safety of the resident is to be provided and may included 1:1 monitoring, moving of the resident, and suspending employees pending the outcome of the investigation. The facility policy, titled "Abuse and Neglect Procedural Guidelines," was reviewed on 10/4/12 at 12:45 p.m. The policy had a revised date of 9/16/2011. The policy indicated an Accident and Incident Report was to be completed and the Incident and Accident Program was to be referred to for investigation procedures. The policy indicated the Executive Director was to be notified of allegations of			

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	abuse immediately. The policy indicated the Executive Director was accountable for investigating and reporting allegations. The policy also indicated an initial report was to be initiated immediately and reported to the applicable state agencies within not more the 24 hours A.4. The record for Resident #E was reviewed on 10/4/12 at 10:30 a.m. The resident's diagnoses included, but were not limited to, dementia, Alzheimer disease, coronary artery disease, and high blood pressure. The 7/12/12 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 6. The score indicated the resident's cognitive patterns were severely impaired. The 7/5/12 Nursing Admission Assessment & Data Collection indicated the resident was admitted on 7/5/12 and the resident had no behaviors at present but did have a history of behaviors. The Mood and Behavior Plan of Care included on the Data Collection above form indicated staff were to approach the resident in a calm manner, assess the resident for behaviors, provide medication per			

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	physician's orders, and refer the resident to Social Services. An "Altercation/Concern Circumstance Assessment and Intervention" form was initiated by Nursing staff on 7/10/12 at 5:00 p.m. The form indicated the resident threw a glass of water at another resident in the dining room. The form indicated the resident had cognitive or memory impairment and difficulty following directions and understanding. The Prevention Update section on the form was completed by the Nurse who initiated the form. Updates circled included to remove the resident from the situation, engage the resident in activities, and encourage family visits. The form was reviewed by the IDT (Interdisciplinary Team) on 7/11/12. This section of the form was signed by four staff members which included ADON, Nursing staff and Social Worker #1. There were no other interventions added by the IDT team. The name of the resident who Resident #E threw the glass of water at was not listed on the above form. Review of the Social Service Progress Notes indicated there were no Social Service progress notes related to the above incident.			

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	When interviewed on 10/9/12 at 11:00 a.m., the Clinical Support Nurse indicated the resident threw a cup of water at Resident #J and also at a staff member on 7/10/12. The Clinical Support Nurse also indicated there was no Incident/Accident Report available related to the above resident to resident altercation. The Clinical Support Nurse indicated the facility protocol requires staff to complete an Incident Report related to resident to resident altercations and to notify the Executive Director of the incident. The Clinical Support Nurse indicated there were no records available to indicate the above incident was reported to the Indiana State Department of Health as required. When interviewed on 10/9/12 at 1:10 p.m., CNA #7 indicated she was present on 7/10/12 when Resident #E threw a cup of water at Resident #J. The CNA indicated both the residents were seated at the table along with Resident J's husband. The CNA indicated she asked Resident #J if she was OK and then Resident #E threw a cup at her also. When interviewed on 10/9/12 at 11:50 a.m., the Interim DON (Director			

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	of Nursing) indicated she was the Assistant Director of Nursing at the time of the above 7/10/12 incident. The Interim DON indicated the resident to resident altercation was reviewed in the IDT morning meeting the following day and the DON was present at this meeting. The Interim Director of Nursing indicated the DON at that time was to "follow up" with the incident. The facility policy, titled "Abuse and Neglect Procedural Guidelines," was reviewed on 10/4/12 at 12:45 p.m. The policy had a revised date of 9/16/2011. The policy indicated an Accident and Incident Report was to be completed and the Incident and Accident Program was to be referred to for investigation procedures. The policy indicated the Executive Director was to be notified of allegations of abuse immediately. The policy indicated the Executive Director was accountable for investigating and reporting allegations. The policy also indicated an initial report was to be initiated immediately and reported to the applicable state agencies within not more the 24 hours. The facility policy, titled "Accident and Incident Reporting Guidelines," was reviewed on 10/4/12 at 2:00 p.m. The			

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	policy was dated 11/2010. The policy indicated an Accident and Incident Form was to be completed for known accidents and abuse allegations. The policy indicated the forms were to include the circumstances surrounding the occurrence, names of witness and their accounts of the occurrence and the statements were to be reviewed by the Administrative staff. The policy indicated all accidents, incidents, and allegations of abuse, including injuries of unknown source, were to be reported to the department supervisor as soon as discovered or when information of occurrence is learned. The policy also indicated reporting of incidents, accidents, and abuse to state and federal agencies shall be in accordance with agency guidelines. The policy also indicated the Accident and Incident form A.5. The record for resident #J was reviewed on 10/9/12 at 12:00 p.m. The resident's diagnoses included, but were not limited to, anxiety, depression, and high blood pressure. The 7/17/12 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 5. This indicated the resident's			

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	cognitive skills for were severely impaired. The 7/12 Nurses' Notes and Skilled Nursing Assessment and Data Collection notes were reviewed. There was no documentation of the resident being involved in any resident to resident altercation on 7/10/12. There was no "Altercation/Concern Circumstance Assessment and Intervention" form initiated by Nursing staff on 7/10/12. There was no documentation of an assessment of the resident's physical or psychosocial status related to the 7/10/12 resident to resident altercation. When interviewed on 10/9/12 at 11:00 a.m., the Clinical Support Nurse indicated the Resident #E threw a cup of water at Resident #J and also at staff member on 7/10/12. The Clinical Support Nurse indicated she identified Resident #J in as the resident who Resident #E threw the cup of water on in reviewing the 7/10/12 resident to resident Altercation report. The Clinical Support Nurse also indicated there was no Incident/Accident Report available related to the above resident to resident altercation. The Clinical Support Nurse indicated the			

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	facility protocol requires staff to complete an Incident Report related to resident to resident altercations and to notify the Executive Director of the incident. The Clinical Support Nurse indicated the above occurrence should have been documented on an "Altercation/Concern Circumstance Assessment and Intervention form in the Resident #J's clinical record including follow up assessment of the resident's condition as per the facility policies. B. The facility Employee Files were reviewed on 10/5/12 at 12:00 p.m. The file for RN #1 indicated the RN was hired on 7/26/12. There were no reference checks in the employee's file. The facility policy, titled "Abuse and Neglect Procedural Guidelines," was reviewed on 10/4/12 at 12:45 p.m. The policy had a revised date of 9/16/2011. The policy indicated all employees were to be screened for a history of abuse, neglect, or misappropriation of property during the hiring process. The policy also indicated screening included obtaining reference checks from previous/current employers. When interviewed on 10/9/12 at			

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	10:00 a.m., the Executive Director indicated there were no reference checks in the RN's file. The Executive Director indicated they obtained the reference checks on 10/8/12. The Executive Director indicated reference checks were to be completed for employees during the hiring process according to the facility's Abuse Policy. This federal tag relates to Complaint IN00117473. 3.1-28(c) 3.1-28(d) 3.1-28(e)			

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F0226 SS=K	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. A. Based on record review and interview, the facility failed to ensure their abuse and neglect policy and procedure was implemented related to the failure to ensure a thorough investigation was conducted for a new onset of vaginal bleeding noted for a resident who was cognitively impaired and required extensive assistance from staff for completing activities of daily living. The facility also failed to ensure a thorough investigation was completed when an allegation was made indicating this resident had injuries that were not self inflicted, and a vaginal tear was documented in hospital records. This affected 1 of 3 residents reviewed for allegations of abuse in the sample of 3. (Resident #C) Due to the lack of thorough investigation, this deficient practice had the potential to affect the 54 residents residing on the health care units who were not protected from further potential abuse, of the 116 residents residing in facility. In addition, the facility failed to	F0226	F226 Resident #C was transferred to the hospital on 9/23/12 for evaluation and treatment of vaginal bleeding. We received verbal notification from the hospital that Resident #C was being admitted with postmenopausal vaginal bleeding. The ER reported dated 9/23/12 also indicated no signs of injury around the vagina. Our plan at that time was to communicate with the family to monitor this resident's condition with anticipated return to our facility. On October 5, 2012, ISDH surveyors initiated a survey at Spring Mill Health Campus to investigate. Between the dates of 9/23/12 and 10/5/12, the facility had no reason to investigate what was believed to be a medical condition and diagnosis. As soon as we were notified of suspicion that the injuries could have been self inflicted or otherwise inflicted, we immediately initiated a full investigation. This resident had already been transferred out of the facility when we learned of the allegation and/or need for investigation. There was no additional need for corrective action(s) for this resident affected	11/08/2012

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	immediately report and initiate investigations in a timely manner for 2 of 2 residents in the sample of 3 who voiced mistreatment by staff and failed to suspend the employees involved in the allegations (Residents #B and #D), and failed to initiate an investigation and report a resident to resident altercation for 1 of 2 resident to resident altercations reviewed in the supplemental sample of 3. (Residents #E and #J) The Immediate Jeopardy began on 9/23/12 when Resident #C was observed with a new onset of vaginal bleeding and an investigation into the bleeding was not initiated. The facility Executive Director, Interim Director of Health Services, and Clinical Support Nurse were notified of the Immediate Jeopardy on 10/4/12 at 4:50 p.m. The Immediate Jeopardy was removed on 10/5/12 at 6:00 p.m., but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. B. Based on record review and interview, the facility failed to implement their abuse and neglect policy and procedure, related to the failure to ensure reference checks		by this deficient practice. Facility did a house wide audit of all incident and accidents to validate a through investigation was completed and report to Indiana State Department of Health. No other findings were noted. Audit was completed on 10/5/2012. All Department Heads were in serviced on 10/5/2012 concerning the Abuse & Neglect and Accident and Incident reporting guidelines. This inservice included the expectation that all reports of alleged abuse must be immediately reported to the Executive Director and/or Director of Health services . An investigation should begin immediately with to include reporting of required state agencies per our Abuse Policy and the Elder Justice Act. Staff accused of abuse will be suspended pending investigation. In addition to department heads being trained, all staff have been inserviced on this policy. Facility staff conducted a survey on 10/5/2012 of interviewable residents ensure they feel safe, their needs are being met and privacy and dignity maintained. All concerns identified during this survey have been reported to facility staff and addressed as indicated. Any issues pertaining to known, suspected or alleged/abuse have been reported to the Indiana State Department of Health with investigations in process as	

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	were completed during the hiring process, for 1 of 5 employee files reviewed (RN #1). Findings include: A.1. The closed record for Resident #C was reviewed on 10/4/12 at 1:30 p.m. The resident's diagnoses included, but were not limited to, dementia, Alzheimer's disease, major depressive disorder, high blood pressure, and coronary artery disease. The resident was sent to the hospital on 9/23/12. Review of the 8/16/12 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 2. This indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required extensive assistance from staff for personal hygiene, eating, dressing, and toilet use. The assessment also indicated the resident required extensive assistance of two or more persons for bed mobility and transfers. A care plan, initiated on 8/13/12, indicated the resident had impaired cognitive skills as evidenced by		applicable. Resident interviews will be conducted with five (5) residents weekly will be conducted by Social Services or designee to ensure residents feel safe, needs are met and privacy/dignity is maintained. Resident to resident altercations was also reviewed with staff to make sure everyone had a clear understand that these should also be considered as an allegation of abuse in some instances. Audits to continue 5 residents weekly for 90 days; then 3 residents weekly for 60 days; then 2 residents weekly for 30 days. We will review in QA monthly until substantial compliance is achieved. Resident concerns will be reviewed by the Executive Director or designee five (5) times per week with timely reporting of known, suspected or alleged abuse and immediate initiation of the investigative process. This will be an ongoing process.We reviewed all personnel files to ensure we were in compliance with all aspects of our Abuse and Neglect Procedural Guidelines. Part of our guidelines include obtaining reference checks for all employees. Any personnel files identified that were missing reference checks have been corrected. Department Heads have been re-trained on the importance of obtaining these reference checks. Our HR Manager will oversee compliance	

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	decision making problems and memory problems. Another care plan, initiated on 8/13/12, indicated the resident had impaired communication, or the potential for, as her primary language was not English. Care plan interventions included for a communication board to be utilized as an alternate form of communicating. The 9/2012 Nurses' Notes were reviewed. The first entry made on 9/23/12 was completed at 10:00 a.m. This entry indicated the resident presented with vaginal bleeding. The Physician and family were notified and orders were obtained to send the resident to the hospital for an evaluation and treatment. There was no assessment of the resident's vaginal area in this entry. There was only one entry made on 9/22/12. This entry was made at 11:00 a.m. There was no documentation of the resident having any vaginal bleeding in this entry. There was only one entry made on 9/21/12. This entry was made at 5:00 p.m. There was no documentation of the resident having any vaginal bleeding in this entry. Hospital documents from the Emergency Room, which were in the resident's clinical record, were		with this expectation. All new employees hired will have reference checks completed before they complete orientation. This will be reported to QA Committee monthly x 4 months then randomly thereafter until concern is determined resolved by QA committee. QA will monitor for any trends and make recommendation to plan of correction as needed. QA will monitor for six (6) months or until compliance is achieved.Correction of citation is 11/8/12.	

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	reviewed. There was a faxed date of 9/28/12 typed on the top right hand corner, indicating they were faxed to the facility on 9/28/12. Emergency Room records dated 9/23/12 indicated the resident was sent to the Emergency Room for an evaluation of vaginal bleeding, and the resident had a history of having a hysterectomy and cardiac surgery. The records indicated there was bleeding around the vagina, no signs of injury around the vagina, and blood clots and discharge from the vagina. The records also indicated the Physician was unable to evaluate the cervix due to the resident being uncooperative, as the resident did not follow commands and was not orientated. Additional hospital records were obtained on 10/4/12 at 3:00 p.m. A 9/23/12 Internal Medicine note, completed by the Physician who was the resident's attending Physician at the facility she was admitted from, indicated the resident was not able to communicate anything, had severe Alzheimer's disease, and the resident was seen in the Emergency Room. The note confirmed the resident was having bleeding from the vagina and not the rectum. A pelvic examination indicated the resident was actively			

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	bleeding from the vagina and no bleeding was noted upon a rectal exam. The note also indicated the resident was status post hysterectomy and the cause of the bleeding was not very clear and a Gynecology consultation was to be obtained for further evaluation. The note also indicated the resident "might have a vaginal wall cancer of some ulcer, possibility of maceration with a hard object should also be considered in demented patient which may have caused laceration and bleeding." A Gynecology Consult Note dated 9/23/12 indicated the resident was admitted for vaginal bleeding and an examination under anesthesia was required. A 9/25/12 Physician Progress Note, completed by the resident's attending Physician, indicated the Gynecologist "observed that there was a tear and other than blood there was a yellow fluid came out [sic] he is concerned that she may have injured her vagina wall with a hard object and may have even rupture [sic] urinary bladder wall." An Operative Record dated 9/26/12 indicated an examination was performed under anesthesia and a speculum examination was done.			

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	Small abrasions were noted at the vaginal vault and some bleeding was noted. The abrasions were cauterized. A 9/26/12 Physician Progress Note, completed by the resident's attending Physician, indicated the resident had a pelvic examination under general anesthesia and was found to have a tear in the vagina. The Assessment section of the note indicated "vaginal bleeding....did she masturbate with a hard object or was it a sexual abuse in the nursing home cannot be determined as patient is demented and cannot give a history..." When interviewed on 10/4/12 at 2:10 p.m. Social Worker #1 indicated the resident's son came into the facility to pick up the resident's dentures and eye glasses on 9/24/12. The Social Worker indicated she gave them to the resident's son at that time. The Social Worker indicated the resident's son did not say anything about the resident's condition at this time. The Social worker indicated the resident's son came back to the facility another time after the above date. The Social Worker indicated he came back to the facility with another person. The Social Worker indicated she could not remember the exact date of this visit.			

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	The Social Worker indicated she asked the son how he was doing and the other visitor told the son "don't say anything." The Social Worker indicated she then asked the son and the other visitor if there was something wrong and requested they come into her office to talk. The Social Worker indicated the other visitor indicated "she has injuries and they are not self inflicted, and we may have a case." The Social Worker indicated to both of them she was going to call the Executive Director to come and talk with them. The Social Worker indicated she tried calling and paging the Executive Director while they were both still in her office but did not get an answer, and the resident's son and the other visitor gave her a business card and left the facility. The Social Worker indicated she then went to the Executive Director's office and informed her what had happened in her office, and that the visitor indicated the resident had injuries that were not self inflicted and gave the card to the Executive Director. When interviewed on 10/4/12 at 2:35 p.m., the Executive Director indicated the Social Worker informed her of the resident's son and the visitor being in the facility and indicating the resident			

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	had some vaginal bleeding and it was "not self inflicted." She indicated this was either last Thursday or Friday. The Executive Director indicated at that time she reviewed the resident's clinical record and called the hospital for the Emergency Room records. The Executive Director reviewed the Emergency Records that were in the resident's record and indicated the date of the fax written on the records was the date the visitors were in and this date was 9/28/12. The Executive Director indicated she also then spoke with the Nurse who was caring for the resident at the time she was sent to the hospital on 9/23/12, the CNA who was working that shift, and the Nurse who worked the shift before. The Nurse who sent the Resident #C to the hospital for the vaginal bleeding indicated this was the first time the resident had any vaginal bleeding. The Nurse on the night shift indicated there were no problems with the resident in the night shift. When interviewed on 10/4/12 at 3:20 p.m., the Executive Director indicated she spoke to the male CNA caring for the resident on the day she was sent out to the Emergency Room and asked him if he had noticed any bleeding in the resident's brief or if			

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	there had been any problems with the resident, and none were voiced. The Executive Director indicated the three staff members were interviewed, but no written statements were available. The facility policy, titled "Abuse and Neglect Procedural Guidelines," was reviewed on 10/4/12 at 12:45 p.m. The policy had a revised date of 9/16/2011. The policy indicated the Executive Director was accountable for investigating and reporting allegations. The policy also indicated the Incident and Accident Program was to be referred to for investigation procedures. The facility policy, titled "Accident and Incident Reporting Guidelines," was reviewed on 10/4/12 at 2:00 p.m. The policy was dated 11/2010. The policy indicated all accidents, incidents, and allegations of abuse, including injuries of unknown source, were to be reported to the department supervisor as soon as discovered or when information of occurrence is learned. The policy also indicated reporting of incidents, accidents, and abuse to state and federal agencies shall be in accordance with agency guidelines. The Immediate Jeopardy that began on 9/23/12 was removed on 10/5/12			

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	when the facility inserviced staff on the Abuse Policy and procedures and reporting any unusual occurrence to their supervisor at the time of the occurrence. All staff working on 10/5/12 had been inserviced. The facility interim Director of Nursing provided a listing of all facility employees with a monitoring system to ensure each employee was inserviced prior to the start of their next scheduled shift. Department Heads were inserviced on the facility Accident and Incident Reporting guidelines to include immediate reporting to the Executive Director/DHS (Director of Health Services) and initiation of investigations. Random verbal audits of several residents were initiated to ensure residents felt safe and their needs were addressed. The audits were to continue. An investigation of Nursing Staff assigned as working the unit for 24 hours prior to the incident was initiated. Incident logs from 7/2012 to current were reviewed for any other potential occurrences. The Immediate Jeopardy was removed on 10/5/12 at 6:00 p.m., but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because			

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	inservicing needed to be provided to all staff prior to returning to work and the facility needed to ensure ongoing monitoring was in place to ensure all allegations of abuse or mistreatment were evaluated thoroughly. A.2. The record for Resident #B was reviewed on 10/4/12 at 10:00 a.m. The resident's diagnoses included, but were not limited to, spinal stenosis, breast cancer, and coronary artery disease. The 7/5/2012 Minimum Data Set (MDS) admission assessment indicated the BIMS (Brief Interview for Mental Status) score was 15. This score indicated the resident's cognitive patterns were intact. An Indiana State Department of Health Incident Report Form was reviewed on 10/4/12 at 10:30 a.m. This incident report form indicated an incident occurred on 8/12/12 at 3:45 p.m. The form indicated the resident reported she did not want the CNA from the midnight shift taking care of her as the CNA was mean and nasty. The report indicated the Immediate Action taken included suspension of CNA #1 and initiating an investigation. The form also indicated the Executive Director was notified.			

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	An Accident/Incident Report was initiated on 8/12/12. The report indicated the resident complained that a CNA was mean and nasty to her and would not help her move her leg. The incident occurred on 8/12/12 at 3:45 p.m. The report also indicated this was reported to the Unit Manager and the resident had no injury. The report was signed as completed by the RN Unit Manager. The facility's investigation was reviewed. The investigation indicated CNA #1 was identified as the CNA working on the night shift 8/11/12 through 8/12/12. The employee time card record for CNA #1 indicated the employee did work the night shift starting on 8/12/12 at 9:57 p.m. and ending on 8/13/12 at 6:13 a.m. When interviewed on 10/4/12 at 11:50 a.m., LPN #6 indicated she was in the resident's room with a CNA on 8/12/12 and the resident voiced the concern that a CNA on the night shift had been mean to her. The LPN indicated she filled out a concern form at the time and reported the concern to the Unit Manager, who was in the facility at the time the above concern was reported to her.			

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	When interviewed on 10/4/12 at 12:25 p.m., the Unit Manager indicated on 8/12/12 at around 3:00 p.m. the Nurse reported to her that Resident #B had indicated a staff member was mean to her. The Unit Manager indicated she was in the facility at the time the Nurse reported this to her. The Unit Manager indicated she did not report this to anyone until the next day when she informed the DON. The Unit Manager indicated the DON then instructed her to interview Resident #B. When interviewed on 10/4/12 at 12:05 p.m., the Executive Director indicated CNA #1 was not suspended at the time the allegation was reported to the Unit Manager as per the facility policy. The Executive Director indicated the CNA time card indicated the CNA worked the night shift on 8/12/12 after the incident was reported on 8/12/12 at 3:45 p.m. The facility policy, titled "Abuse and Neglect Procedural Guidelines," was reviewed on 10/4/12 at 12:45 p.m. The policy had a revised date of 9/16/2011. The policy indicated the Executive Director was accountable for investigating and reporting allegations. The policy also indicated			

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	the Incident and Accident Program was to be referred to for investigation procedures. The policy also indicated upon identification of suspected abuse and neglect protection for the safety of the resident is to be provided and may included 1:1 monitoring, moving of the resident, and suspending employees pending the outcome of the investigation. A.3. The record for Resident #D was reviewed on 10/4/12 at 11:30 a.m. The resident's diagnoses included, but were not limited to, coronary artery disease, atrial fibrillation (an irregular heart beat) and congestive heart failure. The 9/21/12 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 15. This indicated the resident's cognitive patterns were intact. A Resident Concern form was initiated by Social Service #2 on 9/22/12 at 3:35 p.m. The form indicated the resident informed the above staff member he would like to speak to the Unit Manager or DHS (Director of Health Services) regarding a CNA on the midnight shift had refused to help him reposition in bed and told him he do			

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	can it himself. An Indiana State Department of Health Incident Report Form was reviewed on 10/4/12 at 10:30 a.m. The report form indicated an incident occurred on 9/22/12 at 3:45 p.m. The incident description indicated the resident verbalized to Social Service #2 that a CNA on the midnight shift refused to help him reposition in bed. The report indicted the Immediate Action taken included suspension of the CNA and initiating an investigation. Review of the facility's investigation indicated the DON interviewed Resident #D and CNA #6 on 9/25/12. Review of CNA #6's time card records indicated the CNA worked the night shift on 9/23/12. The CNA started work at 9:57 p.m. on 9/23/12 and punched out on 9/24/12 at 6:03 a.m. When interviewed on 10/4/12 at 1:10 p.m., the Clinical Support Nurse indicated the Social Service staff did not inform management of the concern until the staff morning meeting on 9/24/12, and the Social Service staff indicated they then informed her the resident's concern was an allegation of abuse and needed to be investigated and an			

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	investigation was started. When interviewed on 10/4/12 at 1;15 p.m., the Executive Director indicated she was first aware of the resident's concern at the 9/24/12 morning staff meeting and instructed the DON to initiate an investigation. The Executive Director indicated the CNA was not suspended at the time of the allegation. The Executive Director indicated the CNA did not work after 9/24/12 when the allegation was first brought up by Social Service at the 9/24/12 morning staff meeting. The facility policy, titled "Abuse and Neglect Procedural Guidelines," was reviewed on 10/4/12 at 12:45 p.m. The policy had a revised date of 9/16/2011. The policy indicated the Executive Director was accountable for investigating and reporting allegations. The policy also indicated the Incident and Accident Program was to be referred to for investigation procedures. The policy also indicated upon identification of suspected abuse and neglect protection for the safety of the resident is to be provided and may included 1:1 monitoring, moving of the resident, and suspending employees pending the outcome of			

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	the investigation. The facility policy, titled "Abuse and Neglect Procedural Guidelines," was reviewed on 10/4/12 at 12:45 p.m. The policy had a revised date of 9/16/2011. The policy indicated an Accident and Incident Report was to be completed and the Incident and Accident Program was to be referred to for investigation procedures. The policy indicated the Executive Director was to be notified of allegations of abuse immediately. The policy indicated the Executive Director was accountable for investigating and reporting allegations. The policy also indicated an initial report was to be initiated immediately and reported to the applicable state agencies within not more the 24 hours A.4. The record for Resident #E was reviewed on 10/4/12 at 10:30 a.m. The resident's diagnoses included, but were not limited to, dementia, Alzheimer disease, coronary artery disease, and high blood pressure. The 7/12/12 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 6. The score indicated the resident's cognitive patterns were			

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	severely impaired. The 7/5/12 Nursing Admission Assessment & Data Collection indicated the resident was admitted on 7/5/12 and the resident had no behaviors at present but did have a history of behaviors. The Mood and Behavior Plan of Care included on the Data Collection above form indicated staff were to approach the resident in a calm manner, assess the resident for behaviors, provide medication per physician's orders, and refer the resident to Social Services. An "Altercation/Concern Circumstance Assessment and Intervention" form was initiated by Nursing staff on 7/10/12 at 5:00 p.m. The form indicated the resident threw a glass of water at another resident in the dining room. The form indicated the resident had cognitive or memory impairment and difficulty following directions and understanding. The Prevention Update section on the form was completed by the Nurse who initiated the form. Updates circled included to remove the resident from the situation, engage the resident in activities, and encourage family visits. The form was reviewed by the IDT (Interdisciplinary Team) on 7/11/12.			

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	This section of the form was signed by four staff members which included ADON, Nursing staff and Social Worker #1. There were no other interventions added by the IDT team. The name of the resident who Resident #E threw the glass of water at was not listed on the above form. Review of the Social Service Progress Notes indicated there were no Social Service progress notes related to the above incident. When interviewed on 10/9/12 at 11:00 a.m., the Clinical Support Nurse indicated the resident threw a cup of water at Resident #J and also at a staff member on 7/10/12. The Clinical Support Nurse also indicated there was no Incident/Accident Report available related to the above resident to resident altercation. The Clinical Support Nurse indicated the facility protocol requires staff to complete an Incident Report related to resident to resident altercations and to notify the Executive Director of the incident. The Clinical Support Nurse indicated there were no records available to indicate the above incident was reported to the Indiana State Department of Health as required.			

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	When interviewed on 10/9/12 at 1:10 p.m., CNA #7 indicated she was present on 7/10/12 when Resident #E threw a cup of water at Resident #J. The CNA indicated both the residents were seated at the table along with Resident J's husband. The CNA indicated she asked Resident #J if she was OK and then Resident #E threw a cup at her also. When interviewed on 10/9/12 at 11:50 a.m., the Interim DON (Director of Nursing) indicated she was the Assistant Director of Nursing at the time of the above 7/10/12 incident. The Interim DON indicated the resident to resident altercation was reviewed in the IDT morning meeting the following day and the DON was present at this meeting. The Interim Director of Nursing indicated the DON at that time was to "follow up" with the incident. The facility policy, titled "Abuse and Neglect Procedural Guidelines," was reviewed on 10/4/12 at 12:45 p.m. The policy had a revised date of 9/16/2011. The policy indicated an Accident and Incident Report was to be completed and the Incident and Accident Program was to be referred to for investigation procedures. The policy indicated the Executive Director			

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	was to be notified of allegations of abuse immediately. The policy indicated the Executive Director was accountable for investigating and reporting allegations. The policy also indicated an initial report was to be initiated immediately and reported to the applicable state agencies within not more the 24 hours. The facility policy, titled "Accident and Incident Reporting Guidelines," was reviewed on 10/4/12 at 2:00 p.m. The policy was dated 11/2010. The policy indicated an Accident and Incident Form was to be completed for known accidents and abuse allegations. The policy indicated the forms were to include the circumstances surrounding the occurrence, names of witness and their accounts of the occurrence and the statements were to be reviewed by the Administrative staff. The policy indicated all accidents, incidents, and allegations of abuse, including injuries of unknown source, were to be reported to the department supervisor as soon as discovered or when information of occurrence is learned. The policy also indicated reporting of incidents, accidents, and abuse to state and federal agencies shall be in accordance with agency guidelines. The policy also indicated the Accident			

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	and Incident form A.5. The record for resident #J was reviewed on 10/9/12 at 12:00 p.m. The resident's diagnoses included, but were not limited to, anxiety, depression, and high blood pressure. The 7/17/12 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 5. This indicated the resident's cognitive skills for were severely impaired. The 7/12 Nurses' Notes and Skilled Nursing Assessment and Data Collection notes were reviewed. There was no documentation of the resident being involved in any resident to resident altercation on 7/10/12. There was no "Altercation/Concern Circumstance Assessment and Intervention" form initiated by Nursing staff on 7/10/12. There was no documentation of an assessment of the resident's physical or psychosocial status related to the 7/10/12 resident to resident altercation. When interviewed on 10/9/12 at 11:00 a.m., the Clinical Support Nurse indicated the Resident #E			

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	threw a cup of water at Resident #J and also at staff member on 7/10/12. The Clinical Support Nurse indicated she identified Resident #J in as the resident who Resident #E threw the cup of water on in reviewing the 7/10/12 resident to resident Altercation report. The Clinical Support Nurse also indicated there was no Incident/Accident Report available related to the above resident to resident altercation. The Clinical Support Nurse indicated the facility protocol requires staff to complete an Incident Report related to resident to resident altercations and to notify the Executive Director of the incident. The Clinical Support Nurse indicated the above occurrence should have been documented on an "Altercation/Concern Circumstance Assessment and Intervention form in the Resident #J's clinical record including follow up assessment of the resident's condition as per the facility policies. B. The facility Employee Files were reviewed on 10/5/12 at 12:00 p.m. The file for RN #1 indicated the RN was hired on 7/26/12. There were no reference checks in the employee's file. The facility policy, titled "Abuse and			

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	Neglect Procedural Guidelines," was reviewed on 10/4/12 at 12:45 p.m. The policy had a revised date of 9/16/2011. The policy indicated all employees were to be screened for a history of abuse, neglect, or misappropriation of property during the hiring process. The policy also indicated screening included obtaining reference checks from previous/current employers. When interviewed on 10/9/12 at 10:00 a.m., the Executive Director indicated there were no reference checks in the RN's file. The Executive Director indicated they obtained the reference checks on 10/8/12. The Executive Director indicated reference checks were to be completed for employees during the hiring process according to the facility's Abuse Policy. This federal tag relates to Complaint IN00117473. 3.1-28(a)			

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F0250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to provide social services to a resident after a resident to resident alteration for 1 of 2 residents who were reviewed for resident to resident altercations in the sample of 3. (Resident #J) Findings include: The record for Resident #J was reviewed on 10/9/12 at 12:00 p.m. The resident's diagnoses included, but were not limited to, anxiety and depression. The 7/17/12 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 5. This indicated the resident's cognitive patterns were severely impaired. Review of the 7/2012 Nurses' Notes and Nursing Skilled Nursing Assessment and Data Collection forms indicated there was no documentation to the resident being involved in any resident to resident	F0250	Correction action for those residents found to have been affected by deficient practice included a review of Resident #E and #J at the time of this survey. Residents were found to be in no need of additional actions at that time. As part of this overall process with a review of our Abuse and Neglect Procedural Guidelines, all residents in our facility had the potential to be affected by the same deficient practice. Facility staff conducted a survey on 10/5/2012 of interviewable residents ensure they feel safe, their needs are being met and privacy and dignity maintained. All concerns identified during this survey have been reported to facility staff and addressed as indicated. Any issues pertaining to known, suspected or alleged/abuse have been reported to the Indiana State Department of Health with investigations in process as applicable. Resident interviews will be conducted with five (5) residents weekly will be conducted by Social Services or designee to ensure residents feel safe, needs are met and privacy/dignity is maintained. Resident to resident altercations was	11/08/2012

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	altercation in 7/10/12. Review of the 7/2012 Social Service Notes indicated there was no documentation of the resident being involved in any resident to resident altercation. When interviewed on 10/9/12 at 11:00 a.m., the Clinical Support Nurse indicated another resident threw a glass of water at Resident #J on 7/10/12. The Nurse identified the resident as Resident #E. When interviewed on 10/9/12 at 1:15 p.m., CNA #7 indicated she was present on 7/10/12 when Resident #E threw a cup of water at Resident #J. The CNA indicated both the residents were seated at the table along with Resident J's husband. The CNA indicated she asked Resident #J if she was OK, and then Resident #E threw a cup at her also. An "Altercation/Concern Circumstance Assessment and Intervention" form for Resident #E was initiated by Nursing staff on 7/10/12 at 5:00 p.m. The form indicated the resident threw a glass of water at another resident in the dining room. When interviewed on 10/9/12 at 11:00 a.m., the Clinical Support		also reviewed with staff to make sure everyone had a clear understand that these should also be considered as an allegation of abuse in some instances. Audits to continue 5 residents weekly for 90 days; then 3 residents weekly for 60 days; then 2 residents weekly for 30 days. We will review in QA monthly until substantial compliance is achieved. Resident concerns will be reviewed by the Executive Director or designee five (5) times per week with timely reporting of known, suspected or alleged abuse and immediate initiation of the investigative process. This will be an ongoing process.QA will monitor for any trends and make recommendation to plan of correction as needed. QA will monitor for six (6) months or until compliance is achieved. Correction of citation is 11/8/12	

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	Nurse indicated the resident threw a cup of water at Resident #J and also at a staff member on 7/10/12. When interviewed on 10/9/12 at 1:10 p.m., Social Worker #1 indicated if any resident to resident altercation occurred, Social Service was to document the resident's psycho social well being for mental anguish in the Social Service Notes. The Social Worker also indicated the plan of care for the residents should be reviewed related to any resident to resident altercations. The Social Worker indicated this was not completed for the resident. 3.1-34(a)(1)			
R0000	This state residential finding is cited in accordance with 410 IAC 16.2-5.	R0000		

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R0349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure clinical records were accurate and complete related to documentation of the correct code status for resuscitation measures was listed on the monthly Physician Order Statements for 2 of 8 sampled residents reviewed for code status documentation in the sample of 8. (Residents #L and #M) Findings include: 1. The closed record for Resident #L was reviewed on 10/4/12 at 10:30 a.m. The resident was admitted to the Assisted Living from the Health Care unit on 5/22/12. The resident's diagnoses included, but were not limited to, arthritis, right hip fracture, hiatal hernia, and high blood pressure. Review of the 5/22/12 Physician	R0349	R349 All residents resident on our assisted living will be reassessed for code status with physician orders compared to resident and/or family wishes. This will be completed by 11/8/12 for existing residents and will be done for all new admissions. Measure put into place in include retraining of nurses and admissions staff on our procedures for obtaining and documenting code status. Correction action for future monitoring will include having nurses review code status as they review physician orders every month. Any discrepancies will be immediately investigated and corrected. Results of monthly rewrites and concerns with code status will be reported to our QA monthly as needed for at least 6 months and as needed or until we achieve substantial compliance. Correction date 11/8/12	11/08/2012

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	orders indicated the resident's "Code Status" was checked as "DNR" (Do Not Resuscitate). There were no written orders indicating the resident's code status had been changed between 5/22/12 and 5/31/12. Review of the 6/2012, 7/2012, 8/2012, and 9/2012 indicated the resident's "Code Status" was checked as "CPR" (Cardio Pulmonary Resuscitation). When interviewed on 10/4/12 at 2:00 p.m., LPN #5 indicated she was currently managing the Assisted Living units. The LPN indicated Resident #L was re admitted on 5/22/12. The LPN indicated the resident's code status was to be DNR and the orders on the 6/12, 7/12, 8/12, and 9/12 should have been marked DNR instead of CPR. LPN#5 indicated the Physician Order Statements were to be verified by nursing staff every month and corrected. 2. The record for Resident #M was reviewed on 10/5/12 at 2:00 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, Alzheimer disease, vascular dementia, and diabetes mellitus. The			

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	resident was admitted on 6/10/12. Review of the 7/12, 8/12, and 9/12 Physician Order Statements indicated the resident's "Code Status" was blank. The Physician Order Statement indicated either "DNR" or "CPR" was to be checked. When interviewed on 10/9/12 at 9:50 a.m., LPN #5 indicated there were no advanced directives or DNR form completed and the resident's code status was to be CPR. The LPN indicated this should have been checked on each monthly Physician Order Statement. This state residential finding relates to Complaint IN00116313.			